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CLINICS.

CLINICAL LECTURE.

Clinical Lecture on those Symptoms in Women which point to the Expediency of instituting Local Examination. By ROBERT BARNES, M.D., Obstetric Physician to St. Thomas's Hospital, etc. etc.

There is nothing special in the mode of studying the diseases of women. Just as the ophthalmic surgeon is led to examine the eye because the patient complains of loss or disturbance of its function, or because he feels pain in it, or has some other subjective symptom referred to that organ, so by disturbances of function or some other subjective sign are we led to the discovery of disease of the sexual organs. When the function of an organ is disturbed, the *primâ facie* inference is that the organ itself which constitutes the mechanism by which that function is performed is out of gear. This is not indeed always absolutely true; because an impaired state of the blood, or disordered innervation, or derangement of a different organ, may entail the functional disorder which arrests our attention. The genital organs are no exception to this proposition. The functions of the ovaries, uterus, or vagina may be seriously deranged by a state of anæmia or blood-poisoning, by disease of the nervous centres, by disease of the heart, lungs, or liver. These functions may be even more seriously affected by mechanical pressure in contiguous parts. Still the fact remains that we can hardly appreciate rightly or successfully treat these primary or correlated diseases if we do not take into careful consideration the state of the genital organs themselves. The general or distant affections require to be investigated and treated; but it is not safe to overlook the organs that may be secondarily involved.

It is needless to say that every woman who is ill and seeks advice does not suffer

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from disorder of the sexual system. She may labour under various constitutional disorders, and under disorders of parts of the body quite independent of the sexual system. On the other hand, general or local disorders may in their course react upon, and induce disorders in, the sexual system. And there are disorders of this special system, commencing in it, and in their turn reacting upon, and inducing disorder in, distant organs or in the general system.

These inter-reactions are exceedingly frequent. Indeed, it may be affirmed that no severe constitutional disorder can long continue in a woman during the predominance of the ovarian function without entailing disturbance in this function. And the converse is also true, that disorders of the sexual organs cannot long continue without entailing constitutional disorder, or injuriously affecting the condition of other organs.

These facts point to the necessity of guarding against the error of fixing our attention too specially upon one particular class of symptoms or upon one organ. Whilst searching out the part which is more especially the seat of diseased action, we must be careful not to overlook possible disease elsewhere, and not to neglect to observe the mutual reactions. The clinical physician, although led by the intuition of experience to seize quickly upon the offending part, will not omit to pass under review the state and working order of the other parts. In this manner most important complications are often brought most unexpectedly to light; and in every case some useful indication in treatment is discovered. The late Professor Chomel, a man of admirable skill, sagacity, and judgment, never failed, when a new case of disease came under his care, to interrogate successively every function. Thus, I have seen him in a case of pneumonia, the signs of which at once arrested attention, proceed nevertheless to explore the abdomen, the uterus, and the rectum. This may look like carrying out a principle to extremes. Yet who shall say that Chomel, as a clinical teacher or as a physician, was wrong?

It is not, indeed, necessary, in ordinary practice, to follow out in rigorous completeness the plan which to the clinical professor may seem desirable. It will therefore be useful to ascertain *what are the leading symptoms which, alone or grouped, indicate such disorder of the sexual organs as to call for direct exploration.*

This is the question we have set before us: When a woman presents herself, complaining of certain symptoms, chiefly subjective, some, or perhaps none, referred to the pelvis, how are we to act? Will these subjective symptoms enable us to refer them to their cause, to establish a diagnosis, to give satisfactory indications for treatment? Hardly. We must therefore call to our aid the objective signs; we must weigh and determine the significance of these before we can arrive at a conclusion at all precise or trustworthy as to the underlying pathological condition. The whole tendency of modern medicine is to subject every organ which manifests functional disorder to direct physical exploration, in order that it may solve the question presented obscurely by the subjective signs. The sound, the probe, the stethoscope, the laryngoscope, the otoscope, the ophthalmoscope, the various forms of speculum, are only so many contrivances for enabling us to project or extend the senses of touch, sight, and hearing into the internal structures. In the case of the skin, all is at once exposed to direct observation; and, as Alibert remarked, we should be glad to have the same advantage in investigating and treating the diseases of the heart, lungs, liver, kidneys, and nervous centres. Why is it that the study of the pathology of the skin and of the eye is invested with such fascinating interest? Those who devote themselves with the greatest zeal and success to this study will tell you that it is because the skin and the eye reveal their condition directly to the senses, and thus furnish not only positive objective signs which the patient can neither suppress nor misrepresent, but also because in this direct observation of the skin and eye they can read and follow as on a map or on a telegraphic dial the working of distant organs and of many affections of the general system. Here,

then, you see how the reputed special practitioner, turning to account his special experience, often acquires an insight into general pathology denied to those who neglect the lessons they might read upon the visible organs.

This advantage we possess to a great extent of perfection in the case of the pelvic organs. It is by the proper use of this advantage that so great a degree of precision in knowledge, and of success in treatment of diseases of women, has of late years been attained.

And there is one property in a high degree characteristic of the instruments employed in the investigation of the diseases of women of such singular value that it ought to completely silence the objections at one time so passionately urged against them. It is this: the instruments have a therapeutical as well as a diagnostic application; the speculum, for instance, revealing a lesion of the cervix uteri, enables the surgeon at once to apply his remedy. Thus treatment follows upon the track of diagnosis, one sitting and one operation serving for both.

Here, then, as in medicine generally, our first indication of the direction in which we have to look for the disease which causes the patient to complain, lies in the disturbance of function. We have then to consider what these functions are. The first in importance, because it is continued with occasional interruptions throughout the period of active sexual life, is *menstruation*. The other functions are incidental to married life only; these are *the relation to the other sex*, *pregnancy*, and *lactation*.

Most of the diseases which attack the ovaries and uterus, whether primary or secondary, entail some disturbance in the menstrual function. The flow is diminished or in excess, or its periodicity is deranged. It is attended with pain in the pelvic organs and other nervous phenomena.

We shall discuss the history of amenorrhœa, menorrhagia, and dysmenorrhœa hereafter. Our object now is simply to determine the conditions which suggest local examination. In the great majority of cases of *amenorrhœa* in single women, no local exploration is necessary; but in some cases it becomes imperative; for example, amenorrhœa is sometimes presumptive only—that is, the secretion takes place, but, owing to some imperfection of structure, it is retained in the cavity of the uterus or vagina. This may be called *occult menstruation*. The suffering becomes urgent in the highest degree, and nothing short of an operation which shall liberate the retained secretion will save the patient. Some cases, again, of suppressed menstruation, leading to effusion of blood behind the uterus, setting up circumscribed peritonitis, and displacing the uterus so as to press upon the bladder, may cause retention of urine. Here again local examination is imperative. This may be said of every case of retention of urine. In almost every case of retention of urine in women the cause is external to the bladder, and in the great majority it is due to some disease or displacement of the uterus.

Menorrhagia is a relative term; that is, some women lose much more than the average without suffering in health; but whenever the loss continues profuse, obviously entails anæmia and general debility, and persists in spite of internal remedies, local examination is clearly necessary. We shall often find a sufficient local cause in polypus, tumour, inflammation, congestion, hypertrophy, displacement, or malignant diseases, all of which conditions require local treatment.

When we come to study the history of *dysmenorrhœa* we shall find abundant proof of the almost constant association of this disorder with a mechanical condition of the uterus impeding the easy performance of the function. So long, however, as the distress does not clearly affect the general system, so long as it does not exceed endurable bounds, and if it appears to be moderated by general remedies, it is not necessary to examine; but, in the contrary event, examination should not be long postponed. To postpone examination is to postpone discovery of the cause and effective treatment. This is more especially imperative in the case of a married woman in whom dysmenorrhœa is complicated with dyspareunia and ste-

rility. Abortion, if not primarily depending upon some local disease or displacement of the uterus, is so very likely to be followed by some such condition, that an examination should be instituted. If a sanguineous discharge, even periodical, resembling menstruation, goes on during lactation, especially if it be excessive in quantity and attended by leucorrhœal discharge, it may be almost confidently predicated that there exists some uterine disorder requiring local treatment.

I have used a new word, "*Dyspareunia.*" It is incumbent upon every one who coins a new word to explain its meaning and to justify the innovation. Just as the word "dysmenorrhœa" has been coined in order to express compendiously the condition of difficult or painful menstruation, just as "dyspepsia" is used to signify difficult or painful digestion—we want a word to express the condition of difficult or painful performance of the sexual function. Such a word would be convenient in many ways. It would enable us to avoid the longer and coarser forms in use, by substituting a single word at once euphonious, expressive, and in harmony with medical language. After consulting with my colleague, Dr. W. H. Stone, whose high classical attainments give authority to his advice, I have determined to adopt the word "dyspareunia." It is derived from δυσπάρευνος, a word used in this sense by Sophocles. However disagreeable the topic may be, it is impossible to escape reference to a function so important. Dyspareunia in the female is perhaps the most absolute of all the indications of local malformation or disease. It calls the most imperatively for local examination as to its cause. In its milder forms it may make the sufferer's life a course of physical and mental wretchedness; in its severe forms it virtually unsexes her; and in any form it may lead to the most disastrous social calamities.

Taking this condition, dyspareunia, as a symptom of disordered function, we shall be astonished, when we proceed to direct examination of the organs concerned, at finding how many those causes may be, and what a wide field of pathological inquiry is associated with it. For example, there may be original defect or malformation; there may be obstructing tumours or growths, inflammation, dislocation or altered form, disordered innervation—in short, almost every disease to which the sexual organs are liable may entail dyspareunia for one of its consequences; and in not a few of these diseases disregard of this symptom may entail positive danger.

The existence of *certain discharges*, such as blood, under conditions of quantity and times of occurrence which distinguish it from normal menstruation, mucus, pus, albuminous, aqueous, fleshy, or membranous, if at all protracted, point clearly to some local disorder as their origin which requires direct exploration.

Then there are some subjective signs, as pain, lumbo-dorsal, iliac, pelvic, or crural, and a sense of bearing down or pressure upon the rectum or bladder, entailing disorder in the function of these organs. These, especially if connected with abnormal discharges and other symptoms, call distinctly for local investigation.

Then we must observe the constitutional or remote effects of the foregoing conditions. Disorder of the pelvic organs seldom goes on long without entailing anæmia, disordered digestion, hyperæsthesia, neuralgia, or other manifestations of nervous derangement or prostration. Where these conditions are observed in association with marked signs of derangement of function of the pelvic organs, the necessity for exploring the physical state of these is as clear as is that of examining the state of the heart or lungs when these organs perform their function with distress, and the whole system suffers.

Such, then, is a summary view of the conditions, chiefly subjective, which point out to us the desirableness of instituting direct observation of the pelvic organs. This direct observation commonly enables us to analyze the groups of subjective symptoms; to determine the cause and significance of each, separately and collectively. It always brings to our assistance the discovery of other symptoms,

entirely objective; and almost always puts it in our power to apply the proper treatment.—*Lancet*, Oct. 21, 1871.

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Abstract of a Clinical Lecture on the Diagnosis of Urethral and Vesical Diseases. By Sir HENRY THOMPSON, Surgeon to University College Hospital. (Delivered Nov. 21, 1871.)

I commence to-day my usual course of lectures, modified somewhat by circumstances. Thus I desire to condense a little my opening remarks on diagnosis to-day. I may premise that I give this course of lectures on the diseases of the urinary organs because my wards offer you so large a field for their study, and also because there is no class of diseases in which you can afford so much relief to the patient as in this, or so certainly mitigate suffering. There are no diseases more painful, and none the relief of which will gain you more gratitude from your patients.

In the matter of diagnosis, however, it is of the greatest importance that it should be a correct one, and not only correct, but rapidly made. I have now to say what I have said to you before, that I interrogate all these patients on the same system, and I advise you to follow this plan. I employ only four questions for urinary patients, and I advise you to use these four questions also, and always in the same order. The first question is, Is there any deviation in the frequency of passing urine? The second is, Is there any pain in the act? The third is, Is there any blood in the urine? And the fourth is, Are the characters of the urine altered (quality and quantity)?

We shall see that in all cases of urinary diseases these four questions are sufficient, together with the supplementary inquiries which arise out of them; yet we know how often such cases are misunderstood—indeed, the simplest are often mistaken, through not pursuing a systematic method in arriving at a diagnosis. First of all, let us look at the question of *frequency*. Almost every disease of the urinary organs produces some deviation in the natural frequency of passing urine. As a rule, let it be understood that a man in health does not generally rise at night to pass urine, and that he passes it during the day about five or six times; but when there is any degree of inflammatory action in the mucous membrane of the bladder, however slight, frequency of micturition is induced. Now, how does cystitis produce this increased frequency? When the mucous coat of the bladder is inflamed, it cannot bear to be much extended; and when the bladder contains five or six ounces of urine, or even less, the sensitive mucous membrane suggests that it should be emptied; instead of comfortably containing fifteen or sixteen ounces, it cannot endure the extension, and calls on the muscles to contract without delay. There is one, and one only, of these affections which does not necessarily produce, at first, frequent micturition. I speak of stricture: here it always occurs after a time; but a man may have a considerable amount of stricture for years before he is troubled in the way referred to. Calculous disease produces cystitis, and thus causes an increased frequency in passing urine. Now, as a supplementary question, you should next ask, Is the frequency greatest at night or in the day? If a man have calculus in the bladder, he is not so much disturbed at night, but in the day he is frequently micturating—all movements make him do so. Now, that extremely common complaint *hypertrophy of the prostate* is worse at night than by day, as far as frequency of passing urine is concerned. Hence, if a man of about sixty years of age says that he has but recently had urinary troubles, and these are greatest by night, the case is almost made out; you may be sure that a very little further inquiry will demonstrate the fact that he is the subject of hypertrophied prostate.

I come to the second question, of *pain*. This question is of greater significance. Suppose the patient says he feels pain. Where do you feel pain—low down in the belly? Then there is almost certainly chronic cystitis. Suppose he says that his pain is in the penis or perinæum, you must ask if he feels the pain before, during, or after passing urine. If the pain be before, that is because the mucous membrane is

becoming uneasy in consequence of distension. If he find it painful during or after passing urine, and in the end of the penis, he is likely to have stone; and especially, also, if the pain be increased by exercise. The pain is at the end of the penis in stone. It is almost pathognomonic of calculus to find the pain near to the end of the penis during and after micturition. In chronic prostatitis, the pain is also at the end of the penis. This simulates calculus in the bladder more than any other disease.

The third question is, Has *blood* passed? This brings us nearer still to the point. Blood may be seen in cystitis, but very rarely. The mode and the circumstances in which the blood has passed, however, determine the nature of the disease. An elderly man, who passes blood intimately mixed with the urine, dark in colour, and not altered much by circumstances, with frequent rather than painful micturition, has probably hypertrophy of the prostate. In calculus of the bladder you find blood: it is as common in calculus as hæmoptysis is in phthisis. Then a calculous patient will find blood in the urine after a drive or a ride, or after hunting, and none if he keep quiet; or he may pass a drop or two with the last expulsive effort at micturition, and with pain at the time. Such urine is usually rather florid in tint, while, generally speaking, blood passed from the kidney remains long in the bladder, and, from contact with the urine, becomes brown in colour—it is like porter. This, also, may happen when the bleeding is due to hypertrophy of the prostate.

Lastly, Is the *character* of the urine perceptibly changed? A man will often tell you his urine is thick; but he does not discriminate between the thickness of pus or mucus, and that from deposited salts, as lithates. Patients are generally very much disturbed, unnecessarily, on account of thick urine. In this cold weather, the urine, on cooling, deposits its lithates readily, where none would be seen in summer; and you may tell him that, if he apply a little heat to it, he can see for himself that it will become quite clear again, which is never the case if the thickness be due to organic matters like pus or mucus; and if this be not an habitual appearance, you may make light of it. If, on the other hand, a heavy deposit of lithates be constant, you must look into his habits and correct his digestion—probably restrict some indulgence in diet. If, also, the urine do not become clear with heat, you have an organic compound to deal with, and you must find out carefully the source of it.

Let me advise you always to make your patient pass his urine into two vessels for examination. I should not thank you for an examination of urine passed into one vessel; for whatever a man may happen to have lying in the urethra—a passage which is by no means always clear and sound—passes with it. Let him pass an ounce or two into one vessel, and examine only what you find in the second vessel. If there be gleety discharge, if there be stricture of the urethra, you will find shreds of pus and mucus and blood-corpuscles in the first glass, but not in the second. In chronic prostatitis, always in hypertrophy of the prostate, sometimes there will be deposit in the first vessel, which would much mislead you if you imagined it to come from the bladder or kidney. This specimen you must examine for albumen, for sugar, and you must inquire also the quantity passed *per diem*. Well, then, if a patient have told you that he has frequency of passing urine, increased by exercise; that he has pain at the end of the penis; that he passes blood; and that his urine is changed—you may arrive at a pretty good diagnosis of his case. But you would be much to blame if you did not further examine the man: you must pass an instrument. It is best to be straightforward with patients and tell them so. People have too much common sense to be dealt with otherwise than plainly in these matters. You need not always sound a man with a stiff, rigid metallic instrument at first, who has never had an instrument of any kind in his urethra. It is best to take a soft instrument, pass it gently into the bladder, which produces very little discomfort, and so diminish the patient's fear. You can then say, pass another instrument (which will give you a little more pain), and

ascertain completely what is the matter. —*British Med. Journal*, Dec. 9, 1871.

HOSPITAL NOTES AND GLEANINGS.

Summary of Five Cases of Acute Rheumatism in St. Mary's Hospital, with Clinical Remarks on their Duration and Treatment. By Dr. HANDFIELD JONES.—The abatement of the symptoms of acute rheumatism is so gradual that it is difficult to date accurately the cessation of all morbid action; but in the following cases the subsidence of pain, and the decline of the temperature and pulse to the normal standard, have been taken as the guide. If any inaccuracy remains to be allowed for, it is that the duration of the disease has been overestimated rather than the reverse.

In the case of J. E—, aged forty-nine, whose attack lasted about forty-five days, alkalies were resorted to for two days, then quinia in full doses, and lastly strychnia. His urine remained alkaline for sixteen days or more after the alkali had been omitted. A. B——, aged thirty-three, recovered completely in eleven days. Full alkaline treatment was commenced on the fourth day, and gradually slackened. He took no other kind of medicine. In the case of C. G——, aged twenty, the disease lasted only nine days. The treatment commenced on the third day, and consisted exclusively of five-grain doses of quinia, four times a day. His urine was found to be alkaline on the fourth day. J. B——, aged twenty-seven, was admitted on the fifth day of illness, and remained subject to rheumatism about twenty-nine days. Five-grain doses of quinia, repeated four times a day for three days, produced no improvement. He was therefore ordered one grain of iodide of potassium and five grains of the bromide, in two ounces of citrate-of-potash mixture, every two hours. In four days he exhibited a decided improvement, and in a week he was comparatively well. The fifth case was that of a man of good constitution, thirty years of age, who was admitted on the fourth day of his illness. He had full alkaline treatment and none other, and recovered in thirteen days.

Dr. Handfield Jones's remarks on these cases were to the following effect: It is clear that acute rheumatism has not a fixed period of continuance, but is, on the contrary, subject to very considerable variations. The question then arises, on what conditions do these variations depend? To some extent, possibly, on the time which elapses before a case comes under treatment, but to a very much greater extent on the *quality* of the individual system. Some systems present a much greater resisting power to morbid agencies than others, succumb when they are overborne only for a short time, and then rapidly spring back again to health; others when once depressed are very slow to regain their former status. Advanced life and debility, however induced, favour the latter condition. Predisposition to a particular disease must also be taken into consideration: some are prone to gout, some to rheumatism, some to Bright's disease, and some to fatty degeneration; and whatever that predisposition may consist in, the man who is predisposed to rheumatism will succumb more readily to acute rheumatism, and recover more slowly than a man who is not. Therefore, as it is difficult in any given case to form a definite estimate of the strength of a man's constitution, or of his degree of debility, as well as of his predisposition to disease, it is a very difficult matter to determine beforehand the duration of an attack of rheumatic fever.

The next question is, what are the circumstances which should direct the physician in the choice of *remedies*? These also admit of only vague definition. In some measure they depend on the same circumstances which influence the duration of the disease. It is almost certain that as soon as the *urine* becomes alkaline (and it is so sometimes from the commencement), the use of alkalies will be not only useless, but injurious; still more certainly will it be so if the perspiration also be alkaline or neutral. If, on the contrary, the urine be highly acid and rather scanty, alkalies are very likely to be serviceable. When there is great thirst, with a dry, clammy mouth, alkalies in an effervescing form are very grateful. The state of the *pulse* is important. If it be very weak

and soft, alkalies are contraindicated; this is especially the case if, at the same time, the skin yield a copious flow of neutral sweat. In such cases quinia in full doses is very often of great service. Not unfrequently a mixed treatment of alternately given quinia and alkalies, as practised by Dr. Garrod, is productive of much good. In a recent case of a woman who was very weakly, anæmic, menorrhagic, much distressed, restless and half delirious at night, with a high temperature, that treatment was followed in four days by almost entire freedom from rheumatic pain, and by greatly improved sleep, although the temperature remained high for many days afterwards.

The condition of the *nervous system* should be noted. When it is irritable, bromide of potassium and repeated subcutaneous injection of opiates afford more relief than any other measure.

Blisters are allowed by Dr. Gull and Dr. Sutton as valuable agents in relieving suffering, though they do not curtail the course of the disease. But they are not suited to cases in which there is not much inflammatory swelling, although the pain and intolerance of movement be very great; they add to the nervous irritability, and may advantageously be made to give place to continuous poultices, medicated, perhaps, with laudanum or an alkaline solution.

Purgatives, containing calomel, or podophyllin, or extract of colchicum, should always be given at the outset, and repeated according to need if the tongue be foul, the taste perverted, and the patient loathe food.

For the *pains* which are apt to linger *about the shoulders and arms* after all febrile action has ceased, the subcutaneous injection of atropia will generally be found to be the best remedy, but sedative liniments are often useful.

As to *food*, the leading of the appetite should be followed. It can be of no use to intrude on an unwilling stomach food which it cannot digest; but as soon as the patient desires solids he should have them. Until then, soups and milk and such like food are essential.

A high temperature appears to be rather an indication for giving than withholding *stimulants*, and wine should always be given during the febrile stage if the patient be low.

In conclusion, Dr. Handfield Jones said that remedies administered carefully and with discrimination may, and often do, effect much good; and that, although the intimate pathology of acute rheumatism is so little understood that a rational treatment is impossible, no justification can be advanced for the neglect of treatment by drugs.—*Lancet*, Nov. 4, 1871.

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Case of Dislocation of the Left Hip; Reduction by Bigelow's Method.—G. B., a stout, muscular man, æt. 31, a surgeon, was admitted into University College Hospital under the care of Mr. Erichsen, Dec. 18th, with all the ordinary signs of a dislocation of the hip into the sciatic notch. The dislocation had occurred thirteen hours previously, and happened thus: The patient was leaving a railway carriage while the train was still moving, when he stumbled and fell down between the moving train and the side of the platform. He fell on his left side, with his head towards the engine. His left thigh was flexed, and his right extended. He thus got jammed between the carriage and the platform, with his left knee against the carriage and his back against the platform. His back remaining fixed against the platform, and his left thigh being forcibly flexed by the moving carriages, and the space between the carriage and the platform being insufficient, the head of the bone was forced out of the socket when the thigh reached flexion to about a right angle with the body. He saved himself from falling on the rails by clinging to the footboard of the carriage.

Reduction was easily effected. The patient, lying on his back, was placed on a mattress on the floor. He was then fully anæsthetized. Bigelow's directions for the reduction of this dislocation were then followed out exactly. Mr. Godlee, the house-surgeon, standing on the left side of the patient, first flexed the limb to a right angle with the body. He then placed his foot upon the pelvis, to steady it, and made moderately forcible traction

from the flexed knee. The bone went in at once with a loud snap. The whole operation did not last a minute. The force used was by no means great. The limb was then put on a long splint, and the patient put to bed.—*Lancet*, Jan. 6, 1872.

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Hydatid of the Lung.—This is so rare a disease in this country that most practitioners have never seen it. But it seems to be very common in Australia, if we may judge from an interesting paper on the subject by Dr. L. D. BIRD, of Melbourne, read before the Medical Society of Victoria, and published in the March number of the *Australian Medical Journal*. The most common site of pulmonary hydatids is the base of the lung. If the cyst is small or of moderate size, it may occasion no symptoms, and remain unnoticed; when symptoms do occur, they are those of mechanical pressure or irritation. The physical signs vary according to the size and locality of the sac. Unless the tumour infringe on the chest-wall, the percussion-note is not altered, but respiration is harsh and puerile or defective. The rarity of visible venous engorgement is, in Dr. Bird's opinion, a feature which distinguishes the case from one of intrathoracic cancer. If the cyst has originated near the surface of the lung, and is large enough to press on the chest-wall, the limited dulness and other physical signs of fluid will be noticed. The case is to be differentiated from pleurisy, abscess, or phthisis by careful limitation of dulness, the situation of it, and the symptoms and general history of the case. The existence in the sputum of echinococci and portions of cyst would of course be verifying. But this evidence is not available in the early stages of the disease. Hydatids and phthisis often coexist, and it is not always possible to pronounce a positive diagnosis. Dr. Bird claims credit for Victorian surgeons of showing the propriety and harmlessness of tapping these cysts in the lung. In Dr. Bird's experience, the first tapping, followed by medicines calculated further to injure the vitality of the parasite, of which bromide or iodide of potassium and kameela are preferred, is so often successful that he has ceased to take notes of such cases. A discussion followed the reading of the paper. There seemed but one opinion as to the frequency of the disease in the colony, and it was generally attributed to the pollution of drinking-water by the excreta of dogs containing the ova of tænia.—*Lancet*, July 1, 1871.

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Case of Probable Partial Obliteration of the Aorta.—A mason came in 1866 into Prof. SKODA's ward at the General Hospital, Vienna, for some passing affection. In the course of his physical examination of him, Dr. Schrötter, Dr. Skoda's assistant, was led by certain peculiarities which he found, to the above diagnosis, in which Professor Skoda coincided. We were enabled, by the kindness of Dr. Schrötter, to see the man recently, and now give the points in the case as they exist at the present time.

The subject of the supposed malformation is a strong, healthy man of twenty-eight, who works hard all day at his trade, and is able to lift heavy stones, or go through any exertion without fatigue or the slightest distress. On stripping his chest, the first thing noticed was a tremendous heaving apex beat in the sixth intercostal space, two inches outside of the left nipple, evident equally to sight and touch. Percussion showed considerable extension of normal cardiac dulness toward the left. At the apex both sounds were healthy on auscultation. At the third right intercostal space could be heard a loud, rough, systolic murmur, while the second sound was sharp and clear. At the same spot a systolic thrill could be felt on palpation, and a slight heaving of the skin over the space could be seen on looking along the surface of the chest. There were no other auscultatory phenomena. On now examining the radial pulse, it was found to be full and strong, but very slow—only 48 per minute, and Dr. Schrötter said that it ranged normally from 44 to 50. The abdominal aorta could not be felt by deep pressure. In the femoral artery of both sides the pulse was very feeble, and distinctly retarded when compared with the radial.

No enlargement of the superior epigastric branches of either internal mammary artery, or of the epigastric artery itself, can be detected. In the left axilla can be distinctly felt a large pulsating vessel, running almost vertically from above downwards. This is probably an enlarged long thoracic artery. On the right side a similar enlargement does not exist. On the back, between the bases of the scapulæ and the vertebræ, more developed on the left than right side, are two bundles of enlarged vessels, which are evident to the eye, and can be felt pulsating. There can be little doubt that they are branches of the posterior scapular artery, carrying blood into the intercostals; other possible enlarged anastomoses, between branches of the subclavian and axillary arteries and the arteries in the lower part of the body, cannot be made out.

From what has been previously stated, it will be seen that we have evidence here: 1. Of hypertrophy of the left ventricle to a high degree, indicating an obstacle somewhere in the course of the aorta. 2. Of a diminished blood-stream through the aorta and its branches, below the origin of the left subclavian; and of a retarded pulse, showing that the blood takes a perceptibly longer time to get into these vessels at each systole than into the subclavians. 3. Of a normal pulse in the subclavians, and also, it should be added, in the carotids; an indication that the obstacle, whatever it is, lies beyond their origins. 4. Of a compensatory enlargement of certain branches of the subclavian and axillary arteries communicating with arteries which supply the trunk. 5. Of absence of all signs of heart disease, dyspnœa, palpitations, &c., which probably would not be the case if it were the aortic valves which are diseased. 6. Of a *stationary* condition of things. The physical signs are the same now as in 1866.

Finally, it seems that no other diagnosis is possible than that of a partial obliteration of the aorta, somewhere beyond the origin of the left subclavian, probably in the descending part of the arch.

There is one point which is not easy to decide—*i. e.*, the meaning of the murmur in the third intercostal space. Professor Skoda considers that it indicates an enlarged internal mammary artery; but then, why are its abdominal branches and the inferior epigastric artery not enlarged? Dr. Schrötter looks upon it as due to an aneurismal dilatation of the aorta behind the point of contraction, such as would be most likely to follow in the presence of the existing ventricular hypertrophy.

It would be only speculation to consider what further enlarged anastomoses exist in this case. That the compensation is in some way or other made complete is proved by the fact that the man's feet and legs are never cold.—*Lancet*, July 1, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Atomized Turpentine-water in Chronic Bronchitis and Consumption.—Dr. S. Goodwin, of Victoria, Texas, writes us that he has lately been using turpentine-water, inhaled by means of an atomizer, with signal advantage, in cases of chronic bronchitis and consumption, where there was copious expectoration of either mucus or pus, with hemorrhage and violent cough. The turpentine-water is prepared from spirits of turpentine by magnesia in the same way that aromatic waters are commonly prepared by druggists.

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Cancer unsuccessfully treated by Cundurango.—Dr. C. H. Kleinschmidt records (*National Med. Journ.*, January, 1871) a case of scirrhus of the mamma of three years' duration, treated by fluid extract of cundurango, in doses of a drachm three times a day. "The so-called specific," he says, "instead of producing any improvement whatever, acted upon the stomach in a most deleterious manner, at first diminishing and afterwards entirely destroying the appetite.

"On the tenth day of the cundurango treatment nausea and vomiting ensued after each dose of the drug, and continued for some time after. Nothing could be

retained, not even ice. The drug," he thinks, "hastened the fatal termination."

The editors in a note report the following cases communicated to them since their last issue:—

Mrs. C., an aged lady residing in this city, who had been suffering from mammary cancer of long standing, was placed upon the treatment with cundurango. After a few doses of the decoction she commenced vomiting, and continued to vomit for four days, and died.

Mrs. F., who was also under treatment with the drug for a like cause, has also died. The particulars of the case we have not learned.

Mrs. A., who but recently died of an intercurrent disease, was also subjected to the same treatment for supposed mammary cancer, without any beneficial effect. The cundurango was suspended because of the nausea produced. The regular physicians in attendance subsequent to the cundurango treatment, doubt the existence of cancer.

Dr. Garnett says of his case: "I have not hesitated to give it a full and fair trial in the treatment of one of my own patients, unhappily affected with well-marked and unmistakable scirrhus of both mammæ. In this instance the patient has been kept under the administration of the remedy in the form of infusion and fluid extract for eight weeks, without its having produced any visible effect whatever upon the indurated glands, or otherwise influenced the progress of the disease."

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Tapeworm cured by Kameela.—Dr. S. R. KNIGHT bears testimony (*Philadelphia Med. Times*, Jan. 1, 1872) to the efficacy of the kameela (*Rottlera*, U. S. Pharm.) in tapeworm in three cases. He gave it as follows: ℞. Kameelæ ℥ss; syrup. symplicis f℥j. M. Dose, a tablespoonful.

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Hydrate of Chloral as a Rubefacient and Escharotic.—A correspondent of the *Scientific American* strongly recommends the hydrate of chloral as a rubefacient and escharotic. He says: "When applied, the burning is precisely like that produced by a cataplasm of strong mustard; but, at the same time, a sedative action is perceived, which somewhat neutralizes the smarting, while it does not prevent an excessive irritation of the skin. It does not blister, but the part the chloral has been applied to becomes exceedingly inflamed, and more or less swollen; and, according to the length of time of application, shows a merely reddened skin, or a suppuration of several weeks' duration.

"I give you my mode of application: Take a piece of fresh adhesive plaster, of the size wanted, and crush fine, on its surface, with an ivory spatula, enough of the crystals of the chloral to powder the piece of adhesive plaster quite evenly; use the edge of the spatula to take off the chloral where it is more than a mere dust in thickness, but distribute evenly, leaving one-third of an inch margin for adhesion; heat the back of the plaster for an instant only, and apply. Leave it on about half an hour as a rubefacient, six hours as an irritant. To produce suppuration, put the chloral on the plaster in large quantities, and leave on from twenty-four to thirty-six hours; on its withdrawal, apply a stimulating salve, and afterwards heal with cerate. For an escharotic effect, apply the chloral, thickly spread, and, after twelve hours, repeat the application, if necessary.

"It is surprisingly active as a suppurative, and for this reason it will not be prudent to apply it to any part of the surface of the abdominal cuticle, as, in one case under my inspection, having been left on too long, it occasioned a deep ulceration that was difficult to heal."

In this new mode of use, the chloral is truly invaluable; it is easily applied, cleanly, and perfectly reliable.—*Boston Journal of Chemistry*, Jan. 1872.

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An Annual Exhibition for the Philadelphia Meeting of the American Medical Association.—Drs. EDWARD HARTSHORNE and D. MURRAY CHESTON, the Chairman and Secretary of the Committee of Arrangements of the American Medical Association, have issued a circular in which they state they have been authorized to invite attention to the project of an exhibition of objects interesting to the medical profession, to be held in Philadelphia during

the next session of the Association, on the 7th, 8th, 9th, and 10th of May next. This exhibition is designed to resemble the displays of a similar kind which are prominent features of the annual meetings of the British Medical Association.

The aim of the committee will be to form a collection of instruments, apparatus, specimens, preparations, models, drawings, plates, books, and all other proper objects that may be offered in good time for the purpose; and so to arrange it for exhibition as to bring it under the convenient observation of every delegate and professional visitor. They hope, in this manner, to give to the arrangements as much of a professional character as may be in their power. Their desire is to aid in advancing the practical interests of the Association, by affording an attractive addition to the ordinary routine of written and verbal communications and discussions.

The committee appeal for contributions of objects to be exhibited, to members of the medical profession, pharmacists and manufacturers of chemicals, to opticians, instrument-makers, publishers and booksellers, and to all others who are concerned in manufacturing or dealing in whatever tends to illustrate the study and practice of medicine and surgery and the associate sciences.

The general plan of arrangement, and amount of space to be allotted to the several departments and collections, will have to be decided by the end of March; and all the objects to be exhibited must be within reach of the committee by the second or third week of April next.

In order, therefore, to prevent confusion and disappointment, lists of objects offered for exhibition, and estimates of the amount of space desired for the purpose, will be required early.

Communications addressed to Wm. Pepper, M.D., 1215 Walnut Street, and F. F. Maury, M.D., 1218 Walnut Street, the sub-committee on the exhibition, will receive immediate attention.

No special reports or comparative statements need be looked for, nor will the committee be responsible for the merits or demerits of the several objects exhibited, although obliged to exercise control as to admission and location. Novelty, recentness, and practical character will necessarily have weight in determining precedence; but not at the expense of whatever may be deemed especially characteristic or interesting, whether old or new.

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Compliment to Dr. H. J. Bigelow.—Mr. Jonathan Hutchinson, Senior Surgeon to the London Hospital, in a lecture on *Dislocation of the Hip-joint* (*British Med. Journal*, Dec. 23d, 1871), pays the following well-merited compliment to our countryman, Dr. Bigelow:—

"Next, gentlemen, let me say that I regard the researches of Dr. Bigelow in respect to our subject as amongst the most valuable of recent additions to the science of surgery. His essay on the *Mechanism of Dislocation and Fracture of the Hip* I recommend to you most strongly, as an excellent example of experimental investigation applied to a subject concerning which but too many had been contented merely to guess and speculate. I will endeavour to state to you briefly some of the chief results of the Boston professor's work—for details, of course, I must refer you to his book."

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Library of the College of Physicians of Philadelphia.—We are pleased to state that this library continues to increase rapidly. The increase during the past year has been 577 volumes, of which 152 were to the Lewis library, and 425 to the general library. The whole number of volumes in the library is now over 15,500.

—

Reunion of the Alumni of the Jefferson Medical College.—This Association proposes to hold a social reunion during the meeting of the American Medical Association in this city in May next. The alumni of the college are cordially invited to attend. Those who contemplate being present are requested to send their names and addresses to either of the undersigned secretaries: J. Ewing Mears, M.D., 222 S. Sixteenth St., R. J. Dunglison, M.D., 636 N. Eighteenth St., Philadelphia.

Mortality from Smallpox in Philadelphia.—The deaths from smallpox during the past four weeks were as follows:—

Week ending Dec. 30, 1871,	. . .	228
" " Jan. 6, 1872,	. . .	230
" " " 13, "	. . .	216
" " " 20, "	. . .	209

Philadelphia Hospital.—Dr. James Tyson has been elected curator to the Pathological Museum of this hospital to fill the vacancy caused by the resignation of Dr. Wm. Pepper.

FOREIGN INTELLIGENCE.

Croton-chloral.—Dr. Oscar Liebreich, to whom we owe that valuable agent, hydrate of chloral, has lately been engaged in investigating the physiological and therapeutical properties of a new organic compound called croton-chloral, which is formed by conducting chlorine gas into allylene. A peculiar action of this new substance in animals is, that at first a high degree of anæsthesia in the head is produced, while sensibility in the other parts of the body remains intact. The second stage is, that the spinal cord loses its function, and reflex excitability is everywhere extinguished. During that stage both pulse and respiration remain unchanged. The third stage, which is induced by large doses, is characterized by paralysis of the medulla oblongata, and death. Animals may, however, be kept alive by artificial respiration, because the function of the heart is not interfered with; while the ultimate effect of hydrate of chloral is to paralyze the heart. The first therapeutical experiments with the new compound were made in the University Clinique of Berlin. Complete anæsthesia of the fifth pair of cerebral nerves was produced in a child, reflex excitability in the other parts of the body continuing unchanged at the same time. Pulse and respiration remained exactly the same during the whole time of the narcosis. Further experiments in insane patients showed that we possess in croton-chloral a remedy by means of which the brain may be profoundly narcotized without any other functions being disturbed, while by chloral not only the brain, but the nervous system altogether, is rendered anæsthetic, and the heart's action is diminished, which must always constitute a source of danger. Croton-chloral, therefore, promises to produce all the good effects of hydrate of chloral, without any drawback being attached to its judicious use. Its apparently specific effects on the fifth pair of cerebral nerves make us indulge the hope that it may perhaps be found useful in that most intractable affection—true tic douloureux, or epileptiform neuralgia of the face. —*Med. Times and Gaz.*, Nov. 4, 1871.

Popliteal Aneurism cured by Flexion in three days.—The *Bulletin de l'Académie Royale de Médecine de Belgique* contains an account by Dr. Larondelle of the cure of a popliteal aneurism of the size of an orange. Dr. Larondelle adopted Mr. Ernest Hart's method of forced flexion of the leg upon the thigh. There was œdema of the foot and leg. The bandage employed was applied after the fashion recommended by Mr. Hart in his first paper in the *Medico-Chirurgical Transactions;* and the patient, as in his second published case, was allowed to walk about the room with the help of a crutch. The bandage was solidified by starch. The flexion seems to have been forced a little in excess. At the end of the second day, as the patient was complaining much of the pain, the bandage was removed. The pulsation was less. A second bandage was applied, and on the third day the tumour was found to be solidified. The cure thus effected was permanent; and the tumour, at the end of five months, was reduced to the dimensions of a small hard kernel.—*British Med. Journal*, Dec. 23, 1871.

Pure Carbolic Acid for Medicinal Use.—The best preparations of the acid of commerce are seldom free from a disagreeable odour, foreign to the pure article, which renders their use in dentistry or to the throat objectionable. Mr. Church gives the following method of depriving the article of its gas-like odour: One pound

of the best carbolic acid of commerce (the white crystallized acid) is poured into two gallons of cold distilled water, taking care not to permit the *whole* of the acid to enter into solution. With a good sample, if, after shaking repeatedly at intervals, between two and three ounces of the acid remain at the bottom of the vessel used, this will be a sufficient residue to hold and contain all the impurities; with bad samples, less water must be used, or more acid. The watery solution is to be siphoned off, and filtered, if necessary, through fine filter-paper till perfectly clear. It is then placed in a tall cylinder, and pure powdered common salt added, with constant agitation, till it no longer dissolves. On standing, the greater part of the carbolic acid will be found floating as a yellow oily layer on the top of the saline liquor, and merely requires to be removed to be ready for use. As it contains 5 per cent. or more of water, it does not generally crystallize, but it may be made to do so by distilling it from a little lime. The portion collected up to about 365° Fahr. has at ordinary temperatures scarcely any odour, save a faint one resembling that of geranium leaves; and advantage may be taken of this curious resemblance still further to mask the slight odour proper to absolutely pure carbolic acid, by the addition to it of four drops per fluidounce of the French oil of geranium. This addition has the advantage of liquefying the pure crystallized product. The pure acid may be dissolved in 230 parts of water, and used as a gargle; or in 25 parts of water for painting the throat, or in 50 parts for the carbolic spray. We are sure that the profession will thank Mr. Church for the introduction of such a simple method of depriving this invaluable agent of its disagreeable odour.—*British Med. Journal*, Oct. 21, 1871, from *Chemical News*.

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Disinfecting Power of Carbolic Acid.—The disinfecting power of carbolic acid seems yet to be dubious, and certainly not so great as to be relied upon. Dr. H. J. von Ankum inserted a paper in *Moorandschrift voor Natuurwetenschappen* stating the following facts: Atmospheric air, to which are added the vapours emanating from carbolic acid, is unable to hinder the development of lower organisms in water with hay, in milk, and in urine. He put those substances under a glass bell, with an opening at the upper side, and surrounded by little cups filled with carbolic acid. All was placed in a ventilating closet, and the arrangement was such that the air that passed the above-named substances was mixed, if not saturated, with the vapours of carbolic acid. After the lapse of a little time, the development of lower organisms took place just as if the fluids had been exposed to the free air. Von Ankum made use of pure and impure carbolic acid, and only once he saw, in using the impure strong-smelling carbolic acid, the formation of those organisms was retarded, and did not take place in so many forms. He concludes, from his experiments, that no disinfecting action can be expected from the vapours of carbolic acid when they are mixed with the atmospheric air in such quantity that the respirations can take place in it without damage.—*Med. Times and Gaz.*, Dec. 16, 1871.

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Cundurango.—At a recent meeting of the Aerztlicher Verein in Vienna, Dr. Schroff stated that the result of experiments made there with the alleged specific for cancer—cundurango—had shown it to be quite worthless, as our English trials have already proved it to be. The Austrian government had purchased a quantity of this supposed remedy, at a high price, for the purpose of having its effects tested in the Rudolf Hospital.—*British Med. Journal*, Dec. 23, 1871.

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Vaccination with Glycerized Lymph.—Dr. Weiss has contributed some important statistics on this subject to the *Vierteljahrschr. für gerichtl. und öffentl. Medizin.* His observations were made during an outbreak of smallpox among the warprisoners at Alt-Damm in December, 1870, and January and February, 1871. He first vaccinated three children with lymph mixed with glycerine, brought from Berlin. The lymph taken from these children

was mixed with glycerine; and, from January 16th to March 6th, he revaccinated with the diluted lymph 5801 men, the operation being successful in 1586 cases. All the subjects had been vaccinated in youth, many two or three times; and in 4023 there were distinct cicatrices. From November 21st to January 21st, among 2687 men, there were 72 cases of smallpox, with 7 deaths. After the revaccination, from January 25th to April 15th, among 8851 men, there were 195 cases, with 22 deaths; viz., among the successfully revaccinated, 6 cases, no deaths; among those in whom revaccination did not succeed, 25 cases, no deaths; among the unvaccinated, 164 cases, with 22 deaths. Dr. Weiss mixes the lymph from the arm with five parts of glycerine and the same quantity of distilled water. He says that, placed in bottles covered with bladder, it remains good for a long time.—*British Med. Journal*, Dec. 23, 1873.

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Smallpox and Vaccination in Hamburg.—Smallpox has been raging fearfully in Hamburg lately. The following are the official statistics with which we have been furnished. They indicate, as usual, the great extent to which vaccination, even when imperfect or partially worn out, protects from death and modifies the disease, in the cases where, from want of complete or recent vaccination, it has not afforded an entire immunity. The numbers are: vaccinated, recoveries 2954, deaths 347; unvaccinated, recoveries 10, deaths 700. —*British Med. Journal*, Dec. 23, 1871.

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Smallpox in Dublin.—It is stated, on a computation of cases that have come to the knowledge of the authorities, that seven hundred cases of smallpox existed in Dublin on Saturday last, December 16th. Owing to the difference of opinion as to revaccination which exists among the profession in Dublin, the public have not generally adopted this precaution. Very many infants have been found unvaccinated by the City Dispensary medical officers in houses, and even in rooms, and sometimes in the same beds, with persons suffering from the disease. The general rule in such cases has been to vaccinate all such unprotected children immediately; and this step has been generally followed by prevention or diminished severity of the disease.—*British Med. Journal*, Dec. 23, 1871.

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Cholera.—This disease has broken out at Medina, and between September 21 and October 4 (twelve days) 773 deaths took place; all the caravans from Medina to Mecca were consequently compelled to perform quarantine before being allowed to enter the latter city. Cholera is now, however, reported to be present in Mecca; and though Jeddah is yet free from the disease, all arrivals from that place are treated as if suspected of cholera. A cholera death is reported at St. Jean d'Acre in a passenger from Constantinople. Cases have also occurred at Samsoon (though not since November), at Galatz (which is stated to be in a bad sanitary state), at Amol, a place in the neighborhood of the Caspian Sea, and at Astrachan. —*British Med. Journal*, Dec. 23, 1871.

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Oxyhydric Light.—An interesting experiment is in progress (*Lancet*, Nov. 11, 1871) at the Crystal Palace, which is now lighted with the oxyhydric light. The advantages offered by this light are great steadiness, whiteness, and power. It is as superior to common gas-light as that is to a farthing dip. It is produced by effecting combustion by means of pure oxygen instead of by atmospheric air. The great novelty is the mode of preparing the oxygen—viz., by means of manganate of soda, which substance, when alternately heated in air and steam, acts as a carrier of oxygen. Hitherto, the bar to the practical applications of pure oxygen has been the expense of obtaining it; but the new process, which uses up no materials (only the coal necessary to heat the retort and to boil the water), has rendered pure oxygen a very cheap gas. Should the new light become general—and there is a fair chance of its becoming so—we may expect fewer weak eyes.

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The whole work is altogether one of the most instructive we have ever had occasion to peruse, as it could hardly fail to be when it contains the essence of the life-long experience of such a man as Dr. C. J. B. Williams.—*Edinburgh Med. Journal*, Nov. 1871.

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We have been very much pleased by our perusal of this little volume. It is the only one of the kind with which we are acquainted, and practitioners as well as students will find it a very useful guide: for the information is up to the day, well and compactly arranged, without being at all scanty.—*London Lancet*, Oct. 7, 1871.

We think, too, that it will be useful in stimulating the desire to pursue the study of pathological histology; a study which has languished for the want of the necessary schools and text-books.—*National Medical Journal*, Jan. 1872.

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